STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 21 and October 22, 2015.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation and interviews the facility failed to assure the environment was free of hazards related to oxygen cylinders stored in resident rooms (Room #405 and Room #204). The findings are: Observation of Resident Room 405 during the initial tour of the facility on 10/21/15 between 9:00am and 10:30am revealed: -An oxygen concentrator was located to the right of the resident's bed and was running with nasal cannula attached, which was being used by one of the residents. -The location of the oxygen cylinders made it difficult for the resident to get things in and out of her closet. -The unsecured oxygen cylinders created a	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 1	D 079		

potential hazard in the event that they were knocked over.
-Sixteen oxygen cylinders were located in the corner up against the wall by the resident's closet.
-Of the 16 cylinders, one 165 liter oxygen cylinder was stored in a rolling metal stand with nasal cannula attached.
-Of the 16 cylinders, eight 165 liter oxygen cylinders were stored securely in a metal crate.
-Of the 16 cylinders, six were freestanding 165 liter oxygen cylinders and one was small freestanding oxygen cylinder were located beside the metal crate.
-None of the oxygen cylinders were attached to the oxygen concentrator.
-Both residents in the room were asleep.
-There was no signage regarding oxygen being used in resident room.

Interview on 10/21/15 at 3:25pm with the resident who utilized the oxygen in Room 405 revealed:
-She needed the portable oxygen because she was out of her room a lot.
-"Another resident comes in her room and takes her oxygen and takes the tanks back to their room."

Observation of Room 204 on 10/21/15 at 3:30pm revealed:
-An oxygen concentrator was located to the left of the resident's bed and was running with nasal cannula attached, which was being used by one of the resident.
-The unsecured oxygen cylinders created a potential hazard in the event that they were knocked over.
-Sixteen oxygen cylinders were located in the corner up against the wall by the resident's closet.
-Of the 16 cylinders, one 165 liter oxygen cylinder was stored in a rolling metal stand.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 2 -Of teh 16 cylinders, eight 165 liter oxygen cylinders and four small oxygen cylinders were stored in a metal crate. -Of the 16 cylinders, three freestanding small oxygen cylinders were located beside the metal crate. -None of the oxygen cylinders were attached to the oxygen concentrator. -The resident that used the oxygen was sitting on the side of the bed. -The other resident was not in the room. -There was no signage regarding oxygen being used in resident room. Interview on 10/21/15 at 3:35pm with the resident who utilized the oxygen in Room 204 revealed: -She needed the portable oxygen because she was out of her room a lot. -She used oxygen at 2 liters all the time. -The oxygen company delivered and picked up the oxygen cylinders monthly. Interview on 10/21/15 at 3:15pm with the Administrator revealed: -The oxygen cylinders used to be stored in the utility room located next to the nursing station. -The oxygen cylinders were now stored in the resident closets. -He was not sure why the process regarding oxygen storage had changed. -The Supervisor in Charge (SIC) was responsible for monitoring the delivery, pick up and storage of the oxygen cylinders. -The facility used 2 different companies for oxygen delivery and pick up. -The oxygen companies delivered and picked up oxygen on a monthly basis. Observation of Room 405 on 10/22/15 at 8:45am revealed:	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 3 -A total of 15 oxygen cylinders were located in the corner up against the wall by the resident's closet. -One 165 liter oxygen cylinder was stored in a rolling metal stand with nasal cannula attached. -Fourteen 165 liter oxygen cylinders and one small oxygen cylinder were stored in a metal crate. Observation of Room 204 on 10/22/15 at 9:00am revealed: -A total of 16 oxygen cylinders were located in the corner up against the wall by the resident's closet. -One 165 liter oxygen cylinder was stored in a rolling metal stand. -Eight 165 liter oxygen cylinders and seven small oxygen cylinders were stored in a metal crate. Interview on 10/22/15 at 10:05am with SIC revealed: -The facility used to have a room specifically for oxygen storage but "do not use it anymore." -She was not sure why the process for oxygen storage had changed from being stored in the supply room to now being stored in the resident's room. -The oxygen companies delivered and picked up oxygen every week and sometimes every other week. -She had talked to the oxygen companies several times in the past regarding them not leaving so many oxygen cylinders in the resident rooms. -The resident in Room 204 was very active and used approximately 13 large oxygen cylinders a week. -The resident in Room 405 did not leave the facility often and used approximately 6 to 8 large oxygen cylinders a week. -Neither of the residents used the smaller oxygen cylinders often. -She would contact the oxygen companies again	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	Continued From page 4 regarding the deliver and pick up for the oxygen cylinders. The facility submitted a Plan of Protection on 10/21/15 as follows: -The oxygen supplier was contacted on the issue and was asked to supply more metal holding trays or to increase delivery and pick ups so there are not oxygen tanks stored on the floor of resident rooms. -Staff will be educated on the storage regulations of oxygen. -Staff are to notify supervisors when not in compliance with oxygen storage. -Supervisors will monitor oxygen storage compliance and oxygen delivers during the next 3 months and ongoing. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2015.	D 079		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interview and record review, the facility	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	Continued From page 5 failed to assure 1 of 3 sampled staff (Staff C) was tested upon employment for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Staff C's personnel record revealed: - A hire date of 10/23/07 as a Personal Care Aide (PCA). - Documentation of a negative TB skin test on 04/20/05. - Documentation of a negative TB skin test on 04/27/05. - No additional documentation of a TB skin test. Interview with the Supervisor on 10/22/15 at 10:20 am revealed: - She was responsible for completing the employee files. - It was her job to make sure that all required documentation was in each employee file. - Staff C had worked at the facility since 2005. - Staff C had taken a few weeks off from work in 2007, but she was not terminated and she did not cease employment with the facility. -"It was really a leave of absence from the facility, so I did not complete any additional paperwork for Staff C's personnel record when she returned in 2007". Interview with Administrator on 10/22/15 at 9:50 am revealed: - Supervisors are responsible for maintaining the personnel records. - Supervisors make sure everything that is required is in each employee's personnel record. Interview with Staff C on 10/22/15 at 11:15 am revealed:	D 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 131	Continued From page 6 - She had 2 TB skin tests placed when she was hired in 2005. - She did not have any additional TB skin tests placed when she was rehired in 2007. Interview with Staff C on 10/22/15 at 1:35 pm revealed: - She did terminate her employment with the facility "a while back". - "I left for another job, but it didn't work out". - She did not work at the facility for about 3 or 4 months during that time period, which was in 2007. - She came back to the facility and worked as a PCA.	D 131		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record review and interview, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. The findings are: Review of Staff C's personnel record revealed:	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	Continued From page 7 - A hire date of 10/23/07 as a Personal Care Aide (PCA). - A HCPR check performed 08/17/05 with no findings. Interview with the Supervisor on 10/22/15 at 10:20 am revealed: - She was responsible for completing the employee files. - It was her job to make sure that all required documentation was in each employee file. - Staff C had worked at the facility since 2005, but had taken a few weeks off in 2007. - She did not think an additional HCPR check was required since Staff C was not terminated and she did not cease employment with the facility. - It was really a leave of absence from the facility, so she did not complete any additional paperwork for Staff C's personnel record. - No additional paperwork was available for Staff C's personnel file. Interview with Administrator on 10/22/15 at 9:50 am revealed supervisors are responsible for maintaining the personnel records and make sure everything that is required by the state is in each employee's personnel record. Interview with Staff C on 10/22/15 at 1:35 pm revealed: - She did terminate her employment with the facility "a while back", but was unable to recall the date. - "I left for another job, but it didn't work out". - She did not work at the facility for about 3 or 4 months during that time period, which was in 2007. - She came back to the facility and worked as a PCA since 2007.	D 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 137	Continued From page 8 The Business Office Manager provided a HCPR check dated 10/22/15 with no findings. The facility provided a Plan of Protection on 10/22/15 which included: - All personnel records will be pulled and assessed. - A HCPR check will be performed on any personnel record found to need one. - A checklist will the required items for employee personnel records will be utilized to ensure all employee records are up to date. - The Supervisor will monitor the employee personnel records. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2015.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a Criminal Background check was completed prior to hire for 1 of 3 sampled staff (Staff C). The findings are: Review of Staff C's personnel record revealed: - A hire date of 10/23/07 as a Personal Care Aide (PCA). - A criminal background test dated 08/04/05.	D 139		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 139	Continued From page 9 Interview with the Supervisor on 10/22/15 at 10:20 am revealed: - She was responsible for completing the employee files. - It was her job to make sure that all required documentation was in each employee file. - Staff C had worked at the facility since 2005, but had taken a few weeks off in 2007. - She did not think an additional criminal background check was required since Staff C was not terminated and she did not cease employment with the facility. - It was really a leave of absence from the facility, so she did not complete any additional paperwork for Staff C's personnel record. - No additional paperwork was available for Staff C's personnel file. Interview with Administrator on 10/22/15 at 9:50 am revealed supervisors are responsible for maintaining the personnel records and make sure everything that is required by the state is in each employee's personnel record. Interview with Staff C on 10/22/15 at 1:35 pm revealed: - She did terminate her employment with the facility "a while back", but was unable to recall the date. - "I left for another job, but it didn't work out". - She did not work at the facility for about 3 or 4 months during that time period. - She returned to the facility and worked as a PCA.	D 139		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 298	Continued From page 10 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, and interviews the facility failed offer food at 10:00 am that are appropriate to the residents' diet were made available between meals for a total of three times per day. The findings are: Observation on 10/22/15 at 10:00 am of snacks being served revealed: -A Personal Care Aide (PCA) made an announcement at 10:00 am over the intercom snacks were being served in the activity room. -23 resident arrived in the activity room for the morning snack. -A beverage cart was in the activity room which contained coffee and pink lemonade. -The PCA served coffee or pink lemonade to the residents. -No food was offered or made available to the residents. Interview on 10/22/15 at 10:05 am with three residents in the activity room revealed: -Snacks were served 3 times daily at 10:00 am, 2:00 pm, and 7:00 pm. -The morning snack consisted of beverage which was always coffee and some type of juice. -No food was offered during the 10:00 am snack. -Food and beverage was served during the 2:00 pm and the 7:00 pm snack.	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 298	Continued From page 11 Interview on 10/22/15 at 10:10 am with the PCA revealed: -The kitchen staff had prepared the coffle and the pink lemonade for the 10:00 am snack. -She had announced the 10:00 am snack was being offered in the activity room. -The 10:00 am snack consisted of only beverages, food was never served. -The other PCA's had taken juice and coffee to resident's rooms for the 10:00 am snack if they had not came to the activity room. Interview on 10/22/15 at 10:30 am with the kitchen staff revealed: -He prepared the 10:00 am snack for the residents which consisted of coffee and pink lemonade. -He was aware snacks were served three times daily to the residents. -The PCA's were responsible for serving the resident's the snacks. -The resident's snacks were not kept in the kitchen, they were kept in the business manager's office. Review on 10/21/15 at 11:00 am of the facility posted menu revealed: -Snack of choice was listed daily. -Low sodium diets were listed snack of choice low sodium. -Pureed diet snacks were listed pureed snack of choice. -No snack options were listed on the menu. Interview on 10/22/15 at 10:40 with a resident revealed: -He was aware the 10:00 am snack had not included food. -He had never ask for food during the 10:00 am	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 298	Continued From page 12	D 298		

snack, but would like food served.
-The facility had offered a 10:00 am snack in the past which had consisted of food and a beverage but he was not unsure when or why they had stopped.

Observation on 10/22/15 at 10:15 am of a second PCA revealed she took pink lemonade and coffee around to resident's rooms for the 10:00 am snack.

Inteview on 10/22/15 at 11:30 am with the business office manger revealed:
-She was aware only beverages were served to the residents during the 10:00 am snack.
-She kept all the resident's snacks in her office.
-When the snacks were in the in kitchen they were being used by the staff for personal food.

Observation on 10/22/15 at 11:30 am revealed multiple snacks were located in the business manager office which included cookies, crackers, and small cakes.

Interview on 10/22/15 at 1:00 pm with the Adminstrator revealed:
-He was aware the 10:00 am snack consisted of only beverages.
-The 10:00 am snack was served to residents in the past which included food but residents were not eating the food.
-He stopped serving food and only served beverage during the 10:00 am snack several months ago, but still served food and beverage during the afternoon snack as well as the evening snack.
-No residents had complained a food was not served during the 10:00 am snack.
-Some resident had snacks in their rooms which the families had brought into the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 298	Continued From page 13 -He was unaware residents would like food offered during he 10:00 am snack. -He would start immediately serving food along with a beverage during the 10:00 am snack.	D 298		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review the facility failed to assure medication injections (insulin injections) were administered in accordance with infection control measures during the 12:00pm medication pass on 10/21/15. The findings are: Observation of Staff A, Supervisor in Charge (SIC) on 10/21/15 at 11:57am during the lunch medication pass revealed: -Staff A applied hand sanitizer to hands and applied gloves. -Staff A removed a glucometer from the medication cart, which was labeled with the resident's name. -Staff A walked down the hallway to the resident's room. -The medication cart remained outside the dining	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 14	D 371		

room.
-It was approximately 90 feet from the medication cart to the resident's room and back to the medication cart.
-Staff A cleaned the resident's finger with alcohol and obtained a blood sugar level with a disposable lancet.
-Staff A walked out of the resident's room back to the medication cart, which was located outside the dining room.
-Staff A placed the disposable lancet in the sharps container located on the medication cart.
-Staff A placed used gloves in the trash can located on the medication cart.
-Staff A applied hand sanitizer.
-Staff A did not apply gloves.
-Staff A placed Novolog 5 units into a syringe after cleaning the insulin vial with alcohol. (Novolog is a short acting insulin used to lower elevated blood sugar levels).
-The insulin vial was labeled with the resident's name and correct dosage to be administered.
-Staff A left the cap to the insulin syringe on top of the medication cart and walked with the uncapped syringe to the resident's room.
-Staff A walked into the resident's room and informed resident that he would be receiving insulin.
-Staff A cleaned the resident's left upper arm with alcohol.
-Staff A injected the 5 units of Novolog subcutaneously (SQ) into the resident's left upper arm.
-Staff A walked out of the resident's room with the used uncapped insulin syringe back to the medication cart, which was approximately 45 feet away.
-Staff A placed the used uncapped insulin syringe into the sharps container which was located on the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 15 -Staff A placed the insulin syringe cap into the trash can located on the medication cart. -Staff A did not wash her hands and no hand sanitizer was used. Observation of Staff A, SIC on 10/21/15 at 12:10pm during the lunch medication pass revealed: -There were 2 residents beside the medication cart, which was located directly outside of the dining room, waiting to receive their medication. -There were several additional residents entering the dining room for the lunch meal. -Staff A prepared to administer insulin to a resident that sat in a wheelchair beside the medication cart. -Staff A applied gloves without washing her hands. -Staff A placed Novolog 10 units into a syringe after cleaning the insulin vial with alcohol. (Novolog is a short acting insulin used to lower elevated blood sugar levels). -The insulin vial was labeled with the resident's name and correct dosage to be administered. -The resident raised the lower side of her shirt and exposed her lower abdominal area. -Staff A cleaned the resident's abdomen with alcohol. -Staff A injected the 10 units of Novolog subcutaneously (SQ) into the resident's abdomen. -The resident lowered her shirt and made her way via wheelchair into the dining room. -Staff A disposed of insulin syringe into the sharps container located on the medication cart. -Staff A removed gloves and placed in trash can. -Staff A did not wash her hands and no hand sanitizer was used. Observation of Staff A, SIC on 10/21/15 between	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 16 12:12pm and 12:20pm revealed: -Staff A did not wash hands or apply gloves prior to preparing and administering medications. -Five residents received medications by mouth (PO) during this time. -All five residents were given their medications while sitting in the dining room waiting for lunch to be served. Interview on 10/21/15 at 4:45pm with the Administrator revealed: -The facility used 2 types of insulin syringes. -One syringe was for 50 units and the other syringe was for 100 units. -It depended on the amount of insulin that a resident was to receive as to which insulin syringe was utilized. -Neither of the insulin syringes had safety mechanisms. -"Medication Aides should take the medication cart to the resident's room so that the sharps container is easily accessible." -"It depends on the resident when insulin is received outside of the dining room. If the injection is given in the arm, then that is okay. If the medication is given in the belly, then it needs to be in a private setting." -Diabetic training and infection prevention training are completed annually for the MA's. -The Administrator scheduled the annual infection prevention training for November 10, 2015. Interview on 10/21/15 at 4:30pm with the resident who received the insulin injection outside the dining room revealed: -"The staff usually does my blood sugar and insulin administration in the hallway because it is due before I eat lunch." -There are several residents "that have it done too."	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 17 -Her 6:00am blood sugar was completed in her room however; the blood sugar check that was scheduled before lunch and dinner were done in the hallway outside of the dining room. -She usually had the insulin injected in her abdomen. -She did not mind getting her insulin injection in the hallway because she did not think she was exposing herself to others. Interview on 10/22/15 at 9:45am with a second resident revealed: -His insulin was administered in the hallway sometimes in the "lunch line." -He used to have the injection in his belly however; the area "got sore" and now he had the injection in the upper arm. -"I am okay with lifting my shirt in the hallway if the insulin injection is in my stomach." -He was not aware of MA bringing an uncapped insulin syringe into his room prior to insulin being administered. Interview with the SIC on 10/22/15 at 10:15am revealed: -She was responsible for administering medications prior to the lunch meal. -"I have to do 16 blood sugars before lunch. I have several residents that need insulin before they eat lunch." -She usually did the blood sugar monitoring and insulin administration in the resident's room but sometimes she administered insulin in the hallway. -She was unaware if the facility had a policy prior to 10/21/15 that insulin could not be given in the hallway. -She never recapped syringes and always placed used insulin syringes in the sharps container located on the medication cart per the facility	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 18 policy. -She recalled carrying a used insulin syringe out of a resident room and walked down the hallway on 10/21/15 with the uncapped used syringe in a downward position. -She should have pushed the medication cart to the resident's room prior to giving the insulin but was nervous because State surveyors were in the building. Interview on 10/22/15 at 11:20am with the Office Manager revealed: -The annual infection control training class had been scheduled for November 10, 2015. -The SIC and the Office Manager were responsible for scheduling staff training and auditing staff training files. Interview on 10/22/15 at 1:00pm with the SIC revealed she completed the infection control training in February 2014 and was scheduled for the upcoming training in November 2015. Review of Staff A's personnel record revealed she completed the annual mandatory infection prevention training on 02/06/14. The facility submitted a Plan of Protection on 10/21/15 as follows: -The medication cart will be pushed room to room for insulin administration. That way the disposal of syringes is guaranteed to be done in a safe manner. -This process will also provide privacy to the resident. -The facility policy will be that all diabetic testing and insulin will be given before the residents start to enter the dining room. -Education classes will be provided for the MAs and a refresher course on safety.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 19 -The MAs will be monitored by the Administrator. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2015.	D 371		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation and interview the facility failed to assure insulin vials and insulin syringes were maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. The findings are: Observation of the medication cart on 10/21/15 at 11:55am revealed: -The medication cart was located directly outside of the main resident dining room. -The medication cart was unattended by the Supervisor in Charge (SIC), who was responsible for administering medications during the scheduled medication pass.	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 20 -Multiple vials of insulin inside a plastic basket, 2 empty unused insulin syringes with caps attached, 1 labeled resident glucometer meter, 1 vial of glucometer testing liquid, glucometer testing strips, glucometer lancets, and cotton balls soaked in alcohol were on top of the medication cart unattended. -There were 2 residents standing beside the unattended medication cart waiting for their medications before lunch. -The residents were walking by the medication cart as they entered the dining room for lunch. -The medication cart was unlocked as the SIC walked into the dining room. Interview with the Administrator on 10/21/15 at 4:45pm revealed: -Medications were not to be left unattended and were to be stored securely. -"All medication carts were to be locked at all times if they are not in use." -He would meet with all supervisors and Medication Aides to readdress policy and procedure regarding medication storage. Interview with the SIC on 10/22/15 at 10:15am revealed: -She was employed at the facility for 23 years. -She worked as a MA 7:00am to 7:00pm. -She was responsible for administering the medications prior to the lunch meal. -"I have to do 16 blood sugars before lunch. I have several residents that need insulin before they eat lunch. I had walked into the dining room to stir a resident's thickened liquid and I was coming right back to the med cart." -She usually placed medications in the medication cart and locked the medication cart prior to walking away. -The insulin vials were to be locked and kept in	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 21 the second drawer in the medication cart. -She was aware insulin and unused syringes were left unsupervised on top of the medication cart on 10/21/15. The facility submitted a Plan of Protection as follows on 10/21/15: -The Administrator would meet with all supervisors and Medication Aides to address that all medications, syringes, and diabetic testing supplies remain locked up at all times when not personally at the medication carts. -All Medication Aides will be reminded of the policy and procedure. -The Administrator will schedule education and refresher courses immediately and then annually to ensure all medications are safely stored. -The Administrator will monitor compliance of medication storage. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 6, 2015.	D 378		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041003	A. BUILDING: _____ B. WING _____	10/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO RETIREMENT CENTER	3301 GAR PLACE GREENSBORO, NC 27406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 22	D912		

compliance with rules and regulations as related to oxygen storage, health care personnel registry, medication administration, and medication storage.

The findings are:

A. Based on observation and interviews the facility failed to assure the environment was free of hazards related to oxygen cylinders stored in resident rooms (Room #405 and Room #204). [Refer to Tag 0079 10A NCAC 13G .0306(a) (Type B Violation)].

B. Based on record review and interview, the facility failed to ensure 1 of 3 sampled staff (Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire according to G.S. 131E-256. [Refer to Tag 0137 10A NCAC .0407(a)(5) (Type B Violation)].

C. Based on observation, interview and record review the facility failed to assure medication injections (insulin injections) were administered in accordance with infection control measures during the 12:00pm medication pass on 10/21/15. [Refer to Tag 0371 10A NCAC 13G .1004(n) (Type B Violation)].

D. Based on observation and interview the facility failed to assure insulin vials and insulin syringes were maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. [Refer to Tag 0378 10A NCAC 13G .1006(b) (Type B Violation)].